Final Report

GOVERNOR'S TASK FORCE ON THE DEPARTMENT OF CORRECTIONAL SERVICES' MEDICAL SERVICES SYSTEM

July 1, 2000

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
Department of Services ● Department of Regulation and Licensure ● Department of Finance and Support

June 27, 2000

The Honorable Mike Johanns
Governor of the State of Nebraska
P.O. Box 94848
Lincoln, NE 68509-4848

Dear Governor Johanns:

Enclosed you will find the final report of the Governor's Task Force on the Department of Correctional Services' Medical Services System which you appointed in January, 2000. We, the members of the Task Force, thank you for the opportunity to provide you with options that, we hope, will lead to improved policies and practices in the delivery of health care to the State's correctional population.

Given the time and resources available to us, you will not find detailed case studies and investigations of particular incidents or reports in this document. Rather, you will find our analysis and interpretation of such material, which we have reviewed in abundance.

Our detailed conclusions and recommendations add up to a single overarching observation: *In spite of the sincere efforts of a dedicated administrative staff and the commitment of the agency leadership, some important aspects of the health care services delivered by and through the Nebraska Department of Correctional Services do not, at present, conform to the standards of quality health care that we would expect of community facilities and providers.*

At the same time, we conclude that the tone of the report by the Nebraska State Ombudsman issued last fall, in which the Department of Correctional Services is portrayed as organizationally insensitive to the health care needs of its inmates, is unnecessarily provocative and accusatory. *We have found no credible evidence of organizationally supported or motivated intent to harm inmates or to deliver substandard care.*

We believe that the best explanation for the current status of health care within the Department of Correctional Services lies in an understanding of the dynamics of complex systems. Simply put, all systems tend toward entropy and decay unless they are continuously infused with creativity and energy, from both within and without. The legitimate need to maintain a security environment and the limited fiscal and human resources available to State government have not allowed for such infusions.

As system errors and overloads become more the norm, greater and greater amounts of time must be spent dealing with immediate needs, and less and less time can be spent resolving problems at the system level. “Business as usual” can no longer be conducted effectively, but in the absence of any other model, inadequate practices continue to be applied, even as their inadequacy becomes more apparent.

The downward spiral accelerates until finally it becomes impossible to patch and repair the system any longer, and major reforms in structure and approach become imperative. We feel that the system of health care at the Department of Correctional Services has reached such a point.

This system deterioration has occurred within a context of unavoidable tension between the requirements for maintaining authority over inmates who have demonstrated their inability to exercise an expected level of self-control and the inclination of most health care providers to see their patients as unique individuals in need of care and healing. Neither of these concerns can or should be subordinated to the other, but integrating them operationally is a challenge in even the best of environments. Our observation is that some medical staff members have coped with their environment by becoming more distanced from their patients than is, in our opinion, desirable. The balance has shifted, and the inflexible application of often-arbitrary rules and concern over inmate manipulation has come to outweigh many individual needs of patients. The Task Force calls for a restoration of balance in these areas and presents recommendations on how this goal can be accomplished.

During the progress of our study, the Department of Correctional Services has continued to implement improvements in procedures and policies. A number of the actions taken appear to be in accord with recommendations in our report. We applaud these positive steps, and encourage the Department to use them as pathfinders toward more long-term and systematic improvements.

It is our hope that the recommendations contained in this report will provide you with the information you need to set a policy direction that will lead to an enhanced level of quality in health care services in Nebraska’s correctional institutions without compromising the need for security and public safety.

We know that which is measured, improves. Therefore, we urge you to identify another body with medical expertise to conduct a follow-up assessment in two years, to ascertain the progress that has been made during that period.

We wish to note the courtesy and cooperation extended to us by the State agencies involved in our study:

- The Nebraska Department of Correctional Services
- The Nebraska State Ombudsman
- The Nebraska Health and Human Services Department of Regulation and Licensure

We would also like to express our appreciation to the Division of Administrative Services, especially David Montgomery, Ron Briel, and Susan Smith, who supported our work.

We came to our task knowing much about health care and the law, but little about the demands placed upon the health care system when it operates within a secured environment. While we cannot claim to have become experts in this field, we have learned much in an area where few Nebraskans possess true expertise. We hope that our recommendations and advice are just recompense for the understanding we have gained, and we stand ready to serve you again in this area if you feel the need to call on us in the future.

Sincerely,

William Hastings, J.D.
Chairman

Jeffrey Baldwin, Pharm.D.

William Griffin, M.D.

Glen Lau, M.D.

Anne Morse, M.D.

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EXECUTIVE SUMMARY

In January 2000 Governor Johanns appointed a Task Force to review and make recommendations to him regarding the medical services system of the Department of Correctional Services (DCS). The Task Force began its work in January 2000 and completed its work in late June, 2000.

Task Force Findings

The Task Force members found that the current health care delivery system of DCS is affected by circumstances, such as the security environment, that do not pertain in the community. Because of this, achieving community standards of care poses unique challenges. Partially due to the effects of isolation from the mainstream of contemporary health care, DCS does not provide a community standard of care in some areas. Specific areas of care wherein these kinds of concerns are apparent include emergency response, quality assurance, medical treatment and referral policies, health maintenance, surgical policies and practices, mental health and substance abuse policies and practices, medication policies and practices, communicable disease policies and practices, structure and lines of authority, staff and staffing policies, and maintaining a balance between security and financial concerns and the provision of quality health care services.

Task Force Recommendations

The Task Force members made recommendations in the following areas to address the major issues that they identified regarding the health care delivery system of DCS:

- Mission Statement

  The DCS Mission Statement needs to be changed to focus on the effective delivery of community standard health care as well as the administration of health care.

- Quality Assurance

  An effective quality assurance (QA) program must be established by DCS utilizing outside experts.

- Medical Treatment and Referral Policies

  DCS should increase its use of condition-specific treatment protocols and differentiate between treatment of chronic conditions and acute conditions

- Pharmaceutical Policies and Practices

  Pain medication policies and practices need to be consistent and humane.

- Health Maintenance

  Greater emphasis on health maintenance issues is needed in DCS, and specific age-related protocols pertinent to these problems are needed.

- Communicable Disease Policies and Practices

  Community-based standards and protocols need to be developed and implemented by DCS for all communicable diseases.

- Emergency Response

  The DCS emergency response system needs greater consistency, and health care personnel should be provided with adequate training to utilize such life saving technologies as automatic defibrillators.

- Surgical Policies and Practices

  Surgical services provided by DCS must be consistent with the abilities of health care staff to provide them, and any surgery beyond minor office procedures should be referred to facilities outside of the system.

- The Structure and Lines of Authority of the Medical Services System

  Medical services within DCS must have greater autonomy from other components of the Department, and administrative and medical service functions should be separated administratively. Consideration should be given to the creation of an independent body to oversee health care in correctional facilities

- Staff and Staffing Patterns

  Improved standards of competency, performance, and compliance with standard protocols and procedures is needed on the part of DCS health care personnel, and an internal credentialing system must be established. Methods must be found to make DCS more competitive when seeking to hire and retain competent staff.

- Balancing Security and Cost Concerns with the Treatment of Medical Conditions

  Concerns about the cost of treatment and about security should not override the delivery of quality health care to inmates.

- Mental Health and Substance Abuse Issues

  Mental health care and substance abuse treatment should be provided within the mainstream of DCS health care services. The excellent work of the rehabilitation unit should be expanded.

- Additional Recommendations

  An impartial external body that is not affiliated with DCS or the Ombudsman's office, and that has medical expertise, should evaluate inmate complaints regarding health care and treatment.

Follow Up Needed

In order to assess progress in achieving community standards of care in all areas, the Task Force urged that a follow-up evaluation be made by an independent body in two years.

FINAL REPORT
Of the
GOVERNOR'S TASK FORCE
On the
DEPARTMENT OF CORRECTIONAL SERVICES' MEDICAL SERVICES SYSTEM

I. INTRODUCTION

In November, 1999 the State Ombudsman's Office (hereinafter Ombudsman) released a report highly critical of the health care services provided to inmates of facilities operated by the Nebraska Department of Correctional Services (DCS). This report received a great deal of media coverage and attention from State policymakers. The allegations in the report were systematically rebutted by DCS.

Governor Johanns, upon the advice of Harold Clarke, Director of DCS, determined that an impartial panel of experts in the field of health care was needed to evaluate both the information presented in the Ombudsman's report and the general state of health care at the correctional facilities. This Task Force, appointed in December 1999, consisted of:

- Jeff Baldwin, Pharm. D.
- William Griffin, MD
- The Honorable William Hastings
- Glen Lau, MD
- Anne Morse, MD

The Task Force was asked to execute the following general duties:

- Evaluate the adequacy of existing policies and practices governing the DCS medical services system, with special attention to eleven identified areas;
- Consider information contained in recent reports and available from other sources;
- Identify the need for immediate changes and short-term solutions to improve inmate health care; and
- Identify long-term and structural changes that would accomplish the same goal.

The complete text of the Governor's charge to the Task Force is contained in Appendix 1 of this report.

II. BOUNDARIES AND LIMITATIONS

As they surveyed the extent of the charge, the Task Force members determined that initial parameters needed to be set so that the study objectives could be met within the projected time frame. As finally refined, the study:

- uses as its principal evaluative principle the concept of a *community standard of health care*, which means the type, amount, and quality of care that any individual residing in the community in question could expect to receive in that community;

- does not attempt to evaluate or intervene in any individual incidents of care, either in the past or ongoing;

- focuses on health care delivery in three sites: the State Penitentiary in Lincoln, the Omaha Correctional Center, and the Nebraska Correctional Center for Women in York;

- concentrates on physical health care rather than on mental/behavioral health care, while recognizing that, especially in the correctional setting, the distinctions between these areas are often neither obvious nor germane; and

- does not involve the members in any issues regarding personnel actions.

III. OVERVIEW OF TASK FORCE PROCEDURES AND WORK

Summary of Information Used in Formulating Recommendations

The Task Force members used the following types of information in developing their recommendations:

- Testimony from interested parties and the general public
- Letters from inmates and other concerned citizens
- Reports and research articles, including a report from the State Ombudsman
- On-site visits to facilities
- Manuals, protocols, regulations, and standards used by the Department of Correctional Services
- Nebraska Health and Human Services System statutes and regulations
- Textbooks on correctional systems
- Documentation of practice agreements between physicians and physician assistants
- Inmate patient "kites" and other medical records submitted by inmate patients
- Interviews with individual inmates at facilities in three communities
- Our own expertise and judgment in the areas of law, health care, and human behavior

Summary of Task Force Meetings and Activities

The Task Force members met for the first time on January 7, 2000 to receive their charge and to plan the work of the group. At this meeting they also received documents and information from representatives of DCS.

The Task Force members met for their second meeting on February 11, 2000 to discuss information received during and since the previous meeting, and to receive additional information from representatives of DCS

The Task Force members met on February 25, 2000 to tour the Nebraska State Penitentiary, the Department of Correctional Services' pharmacy, and the Work Release Center in Lincoln and then later to receive comments and information from interested parties.

The Task Force members met on March 3, 2000 for a formal public hearing during which extensive testimony was received from members of the public, including former inmates and employees of DCS and family members of current inmates.

During the period March 3-22, 2000 Task Force members made unannounced visits to correctional facilities in Lincoln, Omaha, and York and interviewed individual inmates in confidence. Each interview was conducted by at least two members of the Task Force.

The Task Force members met on March 22, 2000 to discuss information received during and after the public hearing and to discuss the results of site visits and inmate interviews. The latter discussion was done in executive session so that confidential information under discussion would not be made public.

The Task Force members met on April 7, 2000 in executive session to hear confidential information from interested parties.

The Task Force members met on April 14, 2000 in executive session to discuss confidential information and to begin formulating their recommendations.

The Task Force members met on May 2, 2000 in executive session to discuss confidential information and to further develop their recommendations.

The Task Force members met on May 16, 2000 in executive session to discuss confidential information and to further develop their recommendations.

The Task Force members met on June 27, 2000 in open session to finalize their recommendations and approve their report to the Governor. The Task Force members met later that same day with the Governor to discuss their recommendations.

IV. ASSESSMENT OF THE CURRENT SYSTEM

The status of the current health care system within DCS can best be evaluated by comparing that system to the health care practices prevailing within the communities in which the correctional facilities are located. As a working rule, the Task Force members agreed that inmates should receive health care that was *not significantly different*, neither better nor worse, than that person could be expected to receive if presenting with identical conditions, and with coverage by a publicly funded insurance plan, at a community clinic. In addition, the Task Force members acknowledged that any application of this community-standard model had to be modified by taking into account the unique environment of correctional facilities and geographic location in relation to the nearest community with an acute care hospital.

Unique Aspects of the Corrections Environment

The delivery of health care within the correctional system is underlain by a constant and unavoidable tension between the need to maintain a secure environment, including concerns for the personal safety of caregivers, and the need to diagnose and treat patients and provide health care according to the community standard.

It is also clear that the population receiving health care is decidedly not a reflection of the community at large. At each institution the population is segregated by gender. The age distribution excludes those under the age of 16, but persons in the 19-34 age group are strongly over-represented. A very high proportion of inmates have past or current patterns of substance abuse, and a concomitant high prevalence of mental/behavioral problems is also in evidence. Security needs place limitations on the ability of inmates to provide routine self-care that is available to non-institutionalized members of the community. Many inmates exhibit a manipulative approach to the health care system that requires a more skeptical and cautious approach to diagnosis and treatment than would normally be desirable.

Inmates are generally not financially responsible for the non-elective care they receive. This adds a further serious complication to the process of providing care, since, as stewards of public funds, caregivers and administrators must weigh carefully the cost of alternative treatments.

For all of these reasons, the Task Force recognized early on that it would be necessary to expect that the DCS health care system would often have to meet the community standard using methods not employed in the community. This understanding carried through the Task Force investigations and is reflected in the conclusions and recommendations of this report.

The DCS Mission Statement

The mission statement and goals of the Medical Services Section of DCS reads as follows:

> **The mission of the medical services' section, Division of Administrative Services, is to ensure the provision of medical care services to individual inmates within the correctional system and to provide physical examinations to employees who are required by either law or standard to have them.**
>
> **Medical Services Section Goals**
>
> 1. **To ensure the provision of medical care designed to maintain basic health to inmates.**
> 2. **To ensure the provision of dental services designed to maintain basic dental health care of inmates.**
> 3. **To ensure the provision of support services designed to maintain an effective health care delivery system.**
> 4. **To ensure the provision of physical examinations to those correctional employees who are required by either law or standard to have them.**
> 5. **To ensure the efficient and effective administration of Health Care Services.**
>
> The Task Force members reviewed this statement and propose recommended changes to it.

DCS Organizational Structure

Appendix 3 presents the organizational structure through which health care services are administered at DCS. The Medical Director is three steps removed from reporting to the agency head. Not only must the Medical Director report to an Administrator, who is responsible for other areas of health care, such as pharmacy and dentistry; but the position must also report through an Assistant Director who, in addition to health services, is responsible for budgeting, purchasing, engineering, and information systems, among other areas.

The way in which an agency organizes itself to carry out its mission can be revelatory of the emphasis the agency leadership places on elements of its mission. Reasonable persons may disagree over such issues, so long as the desired outcomes are occurring.

But when an area of operations is found to be wanting, *and* the organizational chart indicates that the agency places a fairly low degree of emphasis on that area, reasonable people will often conclude that a re-thinking of priorities could be in order.

While the Task Force members do not believe that shifting boxes on a chart can solve most problems, there are occasions where an agency's organizational decisions predispose some programs to adversity, and that DCS represents such an occasion.

The Kite System and Triage

The basic model through which inmates access the health care system is through a process known as *kiting*. Any inmate wishing to receive medical attention submits a written request called a kite in which he/she states the services needed symptoms, etc. Each kite is reviewed by a member of the medical staff who essentially acts as a triage officer and determines which kites will result in scheduled appointments and which will be rejected. This model has been adopted in preference to a sick-call model, in which inmates seeking health care are permitted to come to the clinic at a set time to visit with a clinician. DCS feels that the sick-call model poses serious security problems by allowing a potentially large number of inmates to congregate at a pre-established place and time. The Task Force encourages the evaluation of the sick call model but does not necessarily endorse this model.

However, use of the kite system for *all* inmate-clinician contacts, including chronic-care follow-ups and requests for durable medical goods, has led to system overload with often-repeated requests for care. To compensate, caregivers seem to have fallen back on a legalistic and artificial selection system. Triage often revolves more around whether the kite has been correctly and completely filled out than around the nature and severity of the complaint. The Task Force concluded that several of the system shortcomings could be attributed to the inadequacies of the kite system, which is in need of a major overhaul.

Assessment Overview

The Task Force members have concluded that there are serious problems with the health care delivery system of the DCS. These problems are cultural, structural, and economic in nature. To correct these problems requires a well-conceived and broad-based strategy of planning and action on the part of many groups including the Legislature, the Governor, DCS, other agencies of state government, and private citizens' groups. Any and all actions taken must be based on an understanding that DCS inmates are a high-risk population from both a medical and a behavioral perspective and that providing a community standard of care to such a population requires out-of-the-ordinary approaches and unusual dedication. Correctional health care *is* different and the methods through which it is delivered must often be creative and innovative.

V. FINDINGS AND RECOMMENDATIONS

Given an understanding of the overall workings and structure of the DCS health care system, the Task Force turned its attention to examining the eleven specific areas set forth in the Governor's charge. In doing so it became evident that the issues involved in these areas – and even more so, the potential remedies – showed a high degree of overlap. The Task Force chose to be true to the spirit, rather than the letter, of the original charge and restructured the areas of investigation in ways that we felt permitted a more comprehensive assessment and analysis of issues. We are confident that in so doing we have investigated and commented upon each of the eleven areas in the original charge.

For each area of investigation, this report first sets forth the pertinent facts, observations, and conclusions that the Task Force feels best pertain to the issue in question. This statement is followed by a number of recommendations that, in the best professional judgment of the Task Force members would improve the effectiveness of health care in this area.

These recommendations are presented as options for consideration by policy-makers. In most instances they are not mutually exclusive, and often represent different types of approaches that could be equally effective. It might be that the implementation of one or two key recommendations in one area would obviate the need for other recommendations in that or other areas to be considered. In short, these recommendations do not constitute a consistent implementation plan or strategy. That work remains to be done. But the Task Force believes that the recommendations offered would provide adequate raw material from which such strategies may be constructed.

A) Mission Statement

The Task Force members feel that there is a need for the DCS to dedicate itself to the goal of providing community standard medical care to inmates at their facilities in Nebraska, and that this goal should be more clearly reflected in the section's statements. The current statements, as cited previously, focus on the *administration*, rather than the *delivery*, of health care services. This is a grievous oversight, since the agency's responsibilities include both administration and service delivery.

The Mission Statement needs to be changed to focus on the effective delivery of community standard health care as well as the administration of health care. For example, goals 1-3 could focus on the outcome of the delivery of care rather than on the design of the care delivery system.

B) Quality Assurance

As they examined the information made available to them, the Task Force members saw a common thread emerge: Many if not most of the accounts of poor treatment or problematic care could be explained by the inadequacies of the Quality Assurance (QA) mechanisms used by DCS. In its simplest form, a QA system sets desired outcomes and standards for the delivery of care, provides for documentation of care rendered and received, performs analyses of unusual or problematic incidents, and yields information on system performance that is then used to improve the system.

It was observed that, while some elements of a QA system are identified by DCS as being in place, in reality there is a very low degree of standardization, documentation, evaluation, and analysis of DCS health care services. Institutional providers have an unusually high degree of latitude in judgment regarding care decisions. Peer review is largely internal. The minutes of the Quality Team meetings reveal a perfunctory approach to the evaluation of cases with adverse outcomes. The use of standard treatment protocols for specific conditions are lacking. There is, in short, an atmosphere of the *ad hoc* surrounding much of the health care delivered by DCS.

The Task Force members concluded that DCS needs to incorporate, whenever possible, consistent and community-based standards of care. DCS must make effective use of outside experts and groups to ensure that inmates receive quality health care services in a consistent manner according to accepted and standardized procedures. The following recommendations are an attempt to accomplish this objective:

1) An effective QA program must be established within DCS medical services utilizing outside experts. This program should be applied to a wide-range of issues such as emergency care, the kite system, women's issues, health screening, the treatment of chronic disease and inmate complaints regarding the quality of services. Over-utilization of the York clinic facility should also be addressed. An effective QA program must be based upon community standards and should involve community representation and inmate representation in the development of protocols.

2) QA must be supported by top management to ensure its success and must be carried out in a positive manner.

3) American Correctional Association guidelines should not be the sole, or even the primary, benchmark for evaluating health care. ACA guidelines do not, in our opinion, adequately address quality of health care. Appendix 2 contains an example of more outcome-oriented standards as proposed by the Institute for Medical Quality. The Task Force does not endorse any specific evaluation system, but we caution against

over reliance on any system that emphasizes the measurement of processes over actual outcomes.

4) Peer review must involve input from outside the system.

C) Medical Treatment and Referral Policies

The Task Force members found that the process by which an inmate accesses the health care system (the "kite system") is flawed by being cumbersome and redundant and puts far too much responsibility on the inmate patient to continually submit new kites in order to get follow-up care. This system is geared almost exclusively to addressing acute care problems and is totally inadequate to handle any chronic care problems of inmate patients.

It was observed in some notable cases that requests for care have been denied on very questionable grounds and that the reviewer had seemingly developed a prejudicial attitude toward the inmate or inmates in question. The Task Force members concluded from these incidents that at least some health care workers in the agency lack sufficient empathy or compassion for inmate patients and that this, too, is a dimension of the health care system that needs to be addressed. The current kite system lacks accountability and appropriate protocols for deciding who gets care and who does not.

Another observation was that DCS medical personnel made no distinction between inmates with chronic health care problems and those with acute medical needs when scheduling persons to be seen by clinicians. This approach runs the risk of needlessly delaying care for acute conditions and of failing to ensure appropriate follow-up and maintenance activities for chronic conditions.

Several issues regarding continuity of care were also noted, such as a disturbing tendency to assess and treat new inmates with little exploration of their existing medical records and prescriptions. Discharge planning for inmates facing release was also found to be inadequate.

The Task Force members found that the DCS health care system either lacks or does not adequately utilize community-based protocols and procedures for the safe and effective delivery of health care services. The result of this situation has upon occasion been disastrous including possible loss of life. Especially noted was the lack of reliance on standard protocols to determine appropriate circumstances for referral outside the correctional facility.

The physical facilities at the State Penitentiary are another cause for concern. The Task Force feels that the emergency room and treatment rooms are undersized by contemporary standards and could inhibit the use of some life-saving equipment

or techniques. DCS medical staff acknowledges that resuscitation efforts (codes), for example, must be treated in the hallway because the patient rooms are too small to allow for the use of a crash cart and attendant personnel.

Pursuant to these concerns, the Task Force members made the following recommendations:

1) Reform the manner in which inmates access the health care system.

- Care for chronic conditions should be rendered primarily through chronic care clinics, as outlined below.
- DCS should create an acute care clinic staffed by at least one PA or MD or Nurse Practitioner in each facility.
- Durable medical goods should be provided without the need for a kite from an inmate.
- It should not be the responsibility of inmates to request follow-up visits. Such visits should be scheduled at the time the patient is first seen for a condition, and should not require repeated kites. Visits should be scheduled in chronic care clinics if appropriate.
- The triage process should be restructured to achieve community-standard access to health care and to ensure accountability.
- A triage system could produce information pertinent to the number of kites per inmate that could provide the informational basis for a review of frequent kites by outside reviewers**.**
- A daily sick call system should be considered as an alternative method to kites for reporting illnesses by inmates.
- Consideration should be given to the idea of charging inmates a small co-pay fee for medical calls in order to reduce inmate manipulation of the system, as is currently done in Kansas, for example. However, there would be no denial of care based on inability to pay. Routine chronic disease care could be exempted from co-payment.

2) Chronic care clinics should be established within DCS similar to those in the Kansas correctional system in order to help the system deal with such disease conditions as diabetes and hypertension.

- Special chronic care clinics should include a rotation of specialists such as internists, dermatologists, and orthopedists.
- It is vital that there be protocols both for the type of care provided and for continuity of care for each type of care provided.
- Protocols should be developed to define the circumstances under which chronically ill inmates should return for a check up and to define when appointments should be made for the next visit with specialists.

3) DCS should place greater emphasis on ensuring continuity of care. For example:

- DCS needs to be more aware of the need to maintain medications and treatment regimens that inmates were on when they entered the system. DCS needs to acquire medical records of new inmates and find appropriate substitutes for medications and other health care needs when indicated.
- DCS should develop and implement a system of general discharge planning for those inmates who are soon to be released and who have chronic health care problems. Also, discharge planning for women inmates could involve the services of the Health and Human Services' Every Woman Matters program.
- A plan is needed to ensure continuity of care during "lock-down" situations. Providing insulin for diabetic inmates would be an example of a situation requiring such a plan.
- DCS needs to ensure that there is continuity of care in situations where contract physicians are supervising DCS nursing staff.
- There is a need to ensure coverage when a contracting MD is unavailable. Each center needs to have access to at least one MD and a PA at all times, and the contracting MD should be held responsible for providing alternative coverage when they are not available. Effective communication between staff within a facility and between facilities needs to be strengthened and maintained.

4) Telemedicine should be aggressively developed to address the needs for specialty consultation while maintaining security. Previous use of telemedicine with the University of Nebraska Medical Center was unsuccessful, but should be re-opened in the light of improved technology. Also, some aspects of telemedicine can be quite useful without being performed in real time, which was previously a stumbling block.

5) All telemetry monitoring should be referred to facilities outside of the system. DCS has neither the financial nor the human resources to provide this service.

6) Treatment protocols should be adopted and used extensively, both for common diseases and health conditions and for unusual and non-routine situations. Common health problems and diseases that can be managed effectively through the use of protocols include: gastrointestinal bleeds, hepatitis C, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), diabetes, hypertension, pain management, headaches, infection control, dental care, routine health maintenance, routine gynecological problems and common surgical

conditions (such as appendicitis, joint disorders, ulcers, e.g.). Such protocols will enhance system accountability, provide the foundation for the QA process called for above, and provide a means to ensure compatibility with community standards.

- Protocols need not be created from scratch. Excellent protocols reflecting the community standard of care already exist for all of the conditions cited above, and many more. Existing protocols may need to be modified for use within the corrections environment, but their essentials are already in place. Experts from outside DCS should review and endorse such protocols prior to implementation.
- In instances where a new protocol must be developed or when an existing protocol must be modified significantly, experts from outside DCS should be heavily involved.
- Deviations from protocol procedures should be documented and reviewed.
- Protocols should include direction for internal specialty clinic and outside referrals and use of telemedicine, as appropriate.
- There needs to be greater consistency and continuity of care across facilities within DCS. Protocols can assist health care personnel in providing consistent care.
- Contractors must follow protocols established by the DCS when providing services.
- Sufficient state funding needs to be provided to establish protocols for DCS health programs using outside expertise.
- Protocols must be reviewed periodically by medical review teams composed of members from inside and outside of the system.
- Protocols regarding the initiation, observance, and termination of do not resuscitate (DNR) orders must be developed and strictly adhered to by all DCS medical staff.
- Inmates should be involved in the development and approval of protocols, and the development of feedback mechanisms to provide the basis for periodic review of the health care system. Inmates should also be involved in the functioning of these feedback mechanisms
- The drug formulary must be based on protocols developed in conjunction with outside experts.

7) Hospital and treatment rooms should be large enough for effective care, and also to accommodate “code” situations.

D) Pharmaceutical Policies and Practices

One of the most disturbing findings of this Task Force was that DCS health care staff seems to have developed a high degree of insensitivity to reports of pain suffered by inmate patients. The reasons for this are clear: pain cannot be objectively measured and can be used by manipulative inmates to gain relief from work detail or access to pain-relieving drugs that are not needed. Concern over providing controlled substances to inmates is also valid. But the Task Force is concerned that the healthy skepticism that must be applied in such circumstances has been carried too far. There are clear incidents of patients who would, by community standards, require pain medications who either did not receive them or who did not receive them in timely and adequate doses. There are also credible reports of guards denying inmates access to pain medications as a method of control or punishment.

The Task Force members conclude that the DCS needs to develop a policy on pain medication that is consistent and humane. The Task Force members concluded that the Department's excessive concern about the abuse of pain medications by inmates has often resulted in denying them the use of medications that could alleviate suffering. The Task Force members believe that the DCS can successfully address concerns about preventing the abuse of pain medications while preventing needless suffering.

When they toured some DCS facilities, Task Force members observed that some medications stored in clinical areas were out-of-date.

The Task Force members made the following recommendations to address these concerns:

1) Pain management protocols should be developed and maintained through the consultation and assistance of pain management professionals from outside of the system. A community-based standard of care needs to be developed and maintained for pain management.

2) Greater awareness of the needs of inmates in legitimate pain is needed on part of DCS staff at all levels of the system. Not all persons reporting pain are being manipulative.

3) Anti-inflammatory drugs should be used when consistent with protocols.

4) The appropriate use of narcotics is not something the system should fear.

5) Community standards should direct all drug therapy.

- A pharmacist (the Director of pharmacy or his or her designee) should be involved in development and maintenance of medication use procedures within protocols.

- Medical staff should define medication dosing and schedules based on community standard protocols.

6) Rationing of medications whether for control or punishment is inappropriate and must not be condoned. Prescribing and dispensing of medications should be done only for medical reasons.

- "Sustained release" narcotics should be used when appropriate.
- Low risk over-the-counter (OTC) medications should continue to be available in the canteen. These and other OTCs should be available through the standard distribution system for both acute and chronic medical conditions as needed.
- Externally applied products such as therapeutic soaps and ointments should be refilled on a regular basis by medical staff as needed. This should be done in accordance with community standards for OTC or pharmacy supplies.
- Security guards or other non-medical personnel should not be involved in making decisions about medication use unless specifically authorized under protocols developed in consultation with outside experts.

7) A system to check and remove out-of-date drugs within the entire system must be implemented and maintained.

8) Inmate patients have the same need to be provided with the same medication counseling information including how and why they should take a given medication, as any other patients.

E) Health Maintenance

DCS health care services focus on the remediation of acute conditions. In part this is due to the inability of DCS to require inmates to pursue preventive health practices.

The Task Force members conclude that the DCS needs to place a greater emphasis on health maintenance issues, especially those pertinent to gender-specific health issues. The Task Force members made the following recommendations to address this concern:

1) System personnel and affected inmates should be educated to deal with fibromyalgia.

2) Protocols must be developed for routine women's health issues such as for mammograms and pap tests.

3) Special age-specific protocols pertinent to health maintenance need to be developed, implemented and maintained for routine care for men and women.

4) An educational program must be established focusing on the prevention of illness for both medical staff and inmates.

F) Communicable Disease Policies and Practices

Persons in the corrections system are at higher risk for communicable diseases. Inmates entering the system have a higher incidence of communicable diseases than a comparable sample of the general public. The close quarters required during incarceration promote the spread of some diseases. Many inmates lack basic knowledge of personal health care and disease prevention.

The Task Force members conclude that the DCS needs to incorporate more community-based standards and practices pertinent to disease detection and control. The Task Force members made the following recommendations to facilitate these goals:

1) All inmates should be screened for (HIV), hepatitis A, B, and C, Tuberculosis (TB), and sexually transmitted diseases (STDs) upon entry and exit.
   - Center for Disease Control guidelines should be used to identify high-risk persons and positive conversions.
   - Routine immunizations should be done on admission for those not currently immune (including for hepatitis B).

2) DCS staff should be adequately protected from communicable disease.
   - DCS personnel who provide health care to inmate patients should be screened on entry into employment for TB, hepatitis A, B, and C and HIV and following any exposure to potentially infectious body fluids. TB screening should occur annually for all DCS employees who provide health care.
   - All medical and security personnel who are not immune to hepatitis B and have not been previously immunized should be immunized for hepatitis B at the expense of the correctional system.

- All personnel who handle or are targeted to handle food should be screened for hepatitis A and any negative results reported before they are allowed to handle food.

3) Community-standard protocols should be developed and used for all communicable diseases.

- New protocols are needed for all specific disease processes (HIV, hepatitis B and C, and STDs, e.g.).
- An infectious disease committee could be formed to develop and review infection control protocols and practices in DCS.

4) Segregation of high-risk inmates with HIV should be based on protocols that identify the grounds for segregation and which also identify the bases for the removal of inmates from segregation. Being segregated or having a positive screening for any disease should not be a reason for denying parole.

5) Any positive screening for any potentially serious and infectious disease should result in the referral of the inmate patient to infectious disease specialists for care.

6) The system should employ and utilize an infectious disease consultant.

7) There is a need for an HIV/AIDS chronic care clinic. This clinic should also include counseling and educational programs pertinent to HIV/AIDS. Special protocols need to be developed that would ensure that those who test positive for HIV/AIDS (or for Hepatitis B or C) would get referred to specialists. Input from an HIV/AIDS expert is needed as part of the services provided in the HIV/AIDS clinic.

G) Emergency Response

Many of the criticisms leveled against health care at DCS involve perceived failings of emergency medical services. Allegations involve inadequate levels of response; slow response; and problems in retrieving the emergency crash cart and gaining access to its contents.

During its tour of the state penitentiary, Task Force members observed the following:

- The emergency room (ER) and patient rooms appeared to be too small to allow full use of emergency medical equipment.
- Only physicians and physician assistants (PA) had training in Advanced Cardiac Life Support.

- The ER crash cart could not be readily unlocked.
- The battery necessary to power the laryngoscope could not be quickly located.
- The most commonly used intubation attachment was missing; officials explained that they had had one on order for about a month.
- Procedures to allow outside rescue vehicles into the penitentiary were time-consuming, although they may be necessary to maintain security.

The Task Force members conclude that the emergency response system of the Department of Corrections needs greater consistency and that DCS health care personnel are not adequately trained to utilize such life-saving technologies as automatic defibrillators. The Task Force members made the following recommendations to address these concerns:

1) Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) Training among DCS employees should be expanded.

   - There should be BLS training for all medical personnel and "first responders" including guards.
   - All physicians, PAs, and any supervisory health staff who work alone must have current certification in ACLS.
   - All BLS and ACLS training should include training in the use of an Automatic Emergency Defibrillator (AEDs); this must also be taught to all currently BLS and ACLS certified employees.
   - There must be a routine retraining schedule for BLS and ACLS**.**

2) A system needs to be developed for administration of emergency support at the site of the emergency using a "quick response team" concept. This concept involves the use of a smaller "bag" or "belt carrier" with an AED, mobile code box and recorder. This assemblage is often referred to as a "grab-and-go bag." This eliminates the need for a crash cart at the site of the emergency. Procedures and protocols must be developed and maintained for its use and a person or persons identified as being responsible for its maintenance.

   - Only ACLS-trained personnel would be qualified to use a grab-and-go bag. However, those with BLS certification should initiate cardiopulmonary resuscitation (CPR) and use AEDs when an emergency situation so requires.
   - A grab-and-go bag should also have IV solutions, glucose solutions, and a mask. Protocols should be developed that define the specific contents of these bags; these should be standardized throughout the system.
   - One large crash cart must be maintained at each correctional facility's hospital (or clinic area when there is no hospital) for use within the hospital, the clinic or both.

- Medications and other equipment for both grab-and-go bags and crash carts should be checked and replaced according to pharmacy protocols.
- There should be sufficient functional and up-to-date back-up equipment available to all grab-and-go bags and crash carts.
- Crash cart and "bag" contents should be checked on a daily basis by someone with that assigned duty and a record kept that is signed by the person responsible indicating that the contents have been checked. Alternatively, a "tear off lock" could be used if the expiration date of the earliest expiring product in the cart or bag is posted on the outside of the cart or bag, and both this and the lock integrity is checked daily.

3) There must be an outside review of all codes by a medical oversight committee, including each emergency medical service (EMS) call. This review should include:

- Reviewing what should be included in crash carts and grab-and-go bags.
- Reviewing protocols for EMS situations in light of events, experience, and good practices.
- Reviewing the actions of DCS personnel and recorded code events/ emergency situations.
- Review of a series of occurrences of the use of grab-and-go bags for at least the first year after their implementation in order to monitor how well this procedure is working. A special committee operating under the auspices of a medical oversight committee could do this and report to the latter committee.
- Review of access procedures for all outside Emergency Medical Technicians (EMTs).

4) Guards should be trained and held accountable for recognizing and taking action in emergency "code" situations including the provision of (BLS). Under this concept, guards would need to have access to AEDs and would be required to carry resuscitation masks and gloves on them so that they are ready for an emergency.

5) A written plan must be developed for emergency response that is consistent throughout the agency's facilities and that includes security personnel in the plan.

6) There should be procedures in place for access to inmate patients by EMTs based outside of the system that is consistent and ensures timely response.

7) The "four-minute" standard for initiation of CPR needs to be reviewed to determine how this standard is defined and whether it is a realistic emergency care objective in DCS, and to recommend a different standard,

if indicated. Such a review needs to include analysis of any variances in response time from facility to facility within DCS and the extent to which such variances are unavoidable and legitimate.

- As much as possible, code response procedures and protocols should be standardized across the system.
- Recording of code events should be required to assist reviewers.
- Inmates need to be a part of any review of EMS procedures or occurrences although specific inmate patient identification should not be revealed.

8) There needs to be a method available to move people to the hospital when appropriate in emergency / code situations. A patient who is, for example, suffering from angina or may have had a heart attack should not be required to walk to the hospital.

H) Surgical Policies and Practice

Surgical procedures at DCS have been criticized for inconsistency. The Task Force attributes this inconsistency to the absence of treatment protocols for common surgical procedures. It is clear that the surgical facilities available within DCS are limited, but the most significant issue seems to revolve around when a patient should be transferred to an outside facility for surgery. A greater reliance on standards, rather than on the judgment of the individual practitioner could help resolve this issue.

The Task Force members want to ensure that the health care services delivered by DCS are commensurate with the capabilities of its personnel and facilities. Pursuant to this the Task Force members made the following recommendations:

1) Any surgery beyond minor office procedures should be considered major surgery and should be referred to facilities outside of the system.

2) All telemetry and chest tube monitoring should be referred outside the system because “in-house” staff lacks the training and time to do these things properly.

3) Pain management must be implemented in appropriate time frames after surgery.

4) DCS needs to develop protocols for optional (non-emergency) surgeries such as for hernia repairs, e.g.

5) DCS needs to carefully document the rationale for decisions on whether or not to operate; these should reflect publicly funded community care standards.

I) The Structure and Lines of Authority of the Medical Services System

The Task Force's concern over the organizational location of medical services within DCS has been raised above. The fact that the medical director reports to the Health Care Administrator, who himself reports to the administrator who has oversight of financial affairs, is deeply troubling. While occasional conflict between the two areas is inevitable, the current DCS organizational system calls for those conflicts to be addressed by a second-level manager (the Assistant Director for Administrative Services) rather than by the agency director.

Further, by making the medical director administratively equal to an associate administrator who is a PA, and thus clinically subordinate to the physician, the DCS system creates a tension that blurs the lines of authority when medical and administrative concerns overlap or conflict.

These comments are not meant to detract from the integrity and capability of the individuals occupying these positions. Rather, they reflect the Task Force's opinion that the current structure creates barriers to the efficient administration of health care and militates against putting medical decisions and financial decisions on an equal footing. The Task Force members are concerned that medical decisions are being overruled by non-medical or subordinate medical personnel based upon financial or security concerns.

The Task Force members concluded that there is a need to reorganize DCS so as to give the medical services' component of the Department greater autonomy from other components of the Department. The Task Force members made the following recommendations to address this problem:

1) Administrative and medical service functions and decision-making processes should be separate, as is the case with the current model of administration within community hospitals. The Task Force members identified three options by which this could be accomplished. These are:

    a) Create an independent medical oversight committee appointed by the Governor that would have authority over the entire medical services division. This body would be composed of two (perhaps three) physicians, a dentist, a nurse, a pharmacist, a hospital administrator, and at least one lay person. There would also be provision under this concept for a mental health consultant and a legal consultant.

Under one version of this concept, the medical director would be hired, retained, and/or dismissed only with the concurrence of the medical oversight committee, and would continue to be a DCS employee. Another option would be to have the medical director employed only by the committee, although this could create complications with respect to his/her authority over the other medical service staff. Under this concept, an assistant medical director would be appointed to oversee credentialing of health care personnel. The State of Florida currently uses a similar approach.

This committee would have to have access to staff support, preferably their own staff, to ensure their independence from other agencies of government.

b) Make the medical director directly responsible to the DCS Director rather than the current arrangement where the medical director reports to financial administrators. This would put the medical director and the medical services division on equal footing with the other divisions of the DCS and would ensure that the agency head, which is directly accountable to the Governor, resolves conflicts.

c) Consider totally privatizing health care within the DCS institutions. The new facility being built in Tecumseh will initiate an experiment with privatized health care and its results should be watched closely. Privatization has been accomplished in other parts of the country, but it raises a whole different set of issues revolving around cost.

2) The medical director must be an energetic individual with a background in primary care and familiar with QA and internal credentialing procedures. The medical director must be accountable for medical care for the entire correctional system and dedicated to the delivery of community-standard health care (rather than that of traditional correctional medicine).

The system needs to recruit a medical director who is willing and able to initiate change to the system consistent with the mission of delivery of health care as a right, not a privilege.

3) A process through which inmates and providers can appeal medical care decisions should be implemented. The appeal should go to the person or group to whom the medical director is accountable.

4) All medical staff should report through medical lines only.

5) There should be a yearly review of all medical procedures including emergency procedures and protocol compliance by outside review.

6) Medical decisions should not be overturned solely because of administrative or financial concerns.

7) Non-physician clinicians should be either health care providers or administrators, but not both.

8) Mental health services should be defined and delivered as part of medical services.

J) Staff and Staffing Patterns

The Task Force found that low morale and indifference to inmate patients on the part of DCS health care staff is a problem. One important reason for this is low pay and poor working conditions for health care workers in DCS. These positions carry the risk of verbal and sometimes even physical abuse by inmate patients. The security environment creates constraints on freedom of movement and can make even routine activities such as ordering in lunch become an ordeal. This environment also, as has been previously noted, requires changes in the methods by which health care is provided. Even simple tasks such as taking a history must be conducted with both security and privacy concerns in mind. Finally, the manipulation and hostility exhibited by many inmates inhibits the natural caring instincts found in many health care providers.

Yet the State of Nebraska pays these employees exactly the same as though they worked in other, less demanding, State government environments!

The Task Force believes that this situation is unfair and unsustainable. It puts DCS at a huge disadvantage when attempting to hire health care workers. Eventually it will result in degradation in the quality of employees; in fact, this may have already begun. Less-qualified employees will ultimately deliver below-standard care. This downward spiral will continue unless this situation is reversed.

It has been suggested that DCS clinicians do not experience some of the burdens of their non-institutional peers such as 24-hour call, the need to carry malpractice insurance, and the insecurities of the marketplace. Yet the fact remains that positions offering these burdens are regularly filled more easily than are the positions at DCS.

The Task Force is aware that other considerations must come into play here, such as the size of the state budget and the need to maintain pay equity among classes of state workers. However, we are equally aware that the inability of DCS to competitively recruit and retain qualified health care employees is a large and growing part of the overall inadequacies in the DCS health delivery system

confronting the state today. It is unlikely that there will be any significant long-term improvement in correctional health care services if the financial status of DCS clinical employees cannot be improved.

It was observed that mandatory supervision of PAs was not always appropriately documented.

With respect to internal credentialing procedures, the Task Force felt that DCS sometimes did not pursue thoroughly its inquiries into the history of proposed clinical employees. Certainly, the credentialing procedures are less rigorous than those used by most community health care facilities. It was also found that internal standards for competency, performance, and compliance with protocols and procedures by health care employees at the Department were not always applied consistently.

The Task Force made the following recommendations in these areas:

1) An internal credentialing program based upon community standards must be established for use in hiring and retaining clinical staff members.

   - The history of each practitioner must be investigated prior to employment using the National Practitioner Data Bank when there is a tested profession.
   - Previous employers should be contacted.
   - A credentialing file should be maintained for each practitioner and re-credentialing should occur every two years.

2) The Task Force does not purport to possess expertise in the area of human resources administration, and thus cannot make a specific recommendation regarding ways to improve the ability of DSC to recruit competitively for health care personnel. However, some of the following might be tried as appropriate:

   - The base salaries for all health care professionals at DCS need to be reexamined for their compatibility with market conditions.
   - Consideration could be given to the idea of implementing hazard pay designation for health care personnel on a case-by-case basis.
   - Explore the possibility of creating a separate pay schedule within the state personnel system for clinical workers at DCS.
   - Identify ways in which indirect methods of compensation might be used to enhance employee satisfaction in these positions.
   - Private funding sources that could be used to augment state resources for health care personnel should be explored.

3) Serious consideration should be given to hiring a full time PA or Nurse Practitioner (perhaps more than one) at the York facility, and a full time

MD at the Omaha facility in addition to the full time PA already there. The Task Force considers present health care coverage at both facilities to be inadequate.

4) Reliable backup is needed for all services provided by a private contractor.

5) Physician supervision of PAs needs to be defined and documented as being in compliance with current statutes and regulations.

- Physician review of records needs to be done on regular basis.
- There is a need to document the number of hours PAs are providing patient care as opposed to other kinds of duties.

- Physicians should review *charts*; not just dictated summaries of all patients who have been seen by a PA, within seven days of care being delivered by the PA.
- The amount of time PAs and physicians spend on site per facility needs to be better defined and documented.
- The PA-physician ratio needs to be better defined and documented.

6) A system for the tracking and monitoring of health professionals pertinent to compliance with statutes and rules and regulations is needed; this should be documented and reviewed by outside reviewers.

7) Effective communication between staff within a facility and between facilities in the system needs to be maintained.

- The medical director should periodically visit all facilities and meet with staff on a regular basis.
- Telecommunications should be explored to facilitate frequent meetings and save travel time.

8) Reliable access to a physician must be obtained and maintained at the York facility. Currently, nurses at this facility are at risk due to the absence of an MD.

9) Nurse practitioners and other advanced-practice nurses could be considered for addition to the professions that provide services at DCS.

10) There is a need for appropriate medical supervision at all DCS sites.

K) Balancing Security and Cost Concerns with the Treatment of Medical Conditions

We citizens ask our correctional services agency to serve multiple masters. We demand fiscal responsibility. We demand the maintenance of security. And we demand community-standard health care. By necessity, then, the officials who lead the corrections system are forever caught in a great balancing act, trying desperately to keep these three headstrong forces working in concert. They are not always successful.

In the opinion of the Task Force, the current corrections system suffers an imbalance that lends greater administrative weight to concerns for cost control and for security than it does to concerns for quality of health care. Without discounting in any way the importance of the other two areas, the Task Force would urge a restoration of balance by augmenting the concern and attention given to health care at DCS.

The Task Force members wanted to ensure that concerns about the costs associated with the delivery of health care services and about security not override the delivery of a community-standard quality of care for inmates. The following recommendations were made to address this issue:

1) Involve security and community EMS providers in the planning and evaluation of procedures for emergency response to ensure timeliness. This planning would involve groups that are both internal and external to DCS.

2) Define appropriate security input pertinent to medical treatment and confidentiality matters in protocols, and ensure that this role is communicated and coordinated with those of health care providers.

   - Medical decisions need to be made by medical personnel, not security personnel unless so directed and guided by an established protocol.
   - Security concerns should not override decisions made by medical personnel regarding the delivery of health care to inmates including prescribed medications except under extraordinary circumstances that must be documented and reviewed by consultants.
   - Medical personnel should request the presence of security personnel only if needed**;** these circumstances should normally be defined in protocol. Any exceptions should be documented and reviewed by outside reviewers.

3) There should be a community-based standard for hourly release of inmate patients on five-point suicide watch. (i.e., Regional Center policies).

4) The system should examine telemedicine (not necessarily real time), as a delivery alternative for health care and educational needs.

5) Under all but the most unusual circumstances (subject to documentation and review), nothing less than community-standard care should be offered.

- Cost should not be a reason to deny appropriate medical care.
- Administrative or security concerns should not be a reason to deny appropriate care.

6) The medical director should be responsible for input to the DCS director pertinent to cost-effectiveness of treatment practices parallel to the input of the administrative director.

L) Mental Health and Substance Abuse Issues

Technically speaking, the mental health and substance abuse programs of DCS lie beyond the scope of the charge given to the Task Force. However, in the corrections environment it is often neither possible nor desirable to segregate physical and behavioral health care. The pathologies presented by many inmates involve such a complex mix of physical and psychosocial dysfunction that any one-dimensional treatment plan is clearly incomplete.

In the course of their investigation, the Task Force observed that the Lincoln DCS facilities excel in their drug rehabilitation program. In light of this demonstrated excellence, the Task Force made the following recommendations:

1) There is a need to better integrate mental health care into the mainstream of health care services of DCS. Mental health services should be provided within the context and administrative structure of the health care services system of the agency.

2) The prospect of increasing the number of mental health personnel in the system should be examined.

3) The drug rehabilitation program should be funded at a higher level consistent with community standards with expanded availability to inmates.

M) Additional Recommendations

The work of the Task Force resulted in a number of recommendations that do not easily fit into any of the categories above. Again, some of these may be outside the charge to the Task Force, but the members felt them to be important components of a systematic appraisal of corrections health care.

Several observations involve internal communications within DCS. The Task Force understands that the corrections environment mandates a great degree of formalization of communication. However, the rigidity of communication lines that was observed appears to be greater than necessary for even an environment such as this. Interpersonal frictions that could be resolved by informal means are allowed to rise to the level of conflicts before being addressed and then only through formal modes. Communication among professionals at different DCS facilities is inconsistent and inadequate. Communication between the health cares system and the security system is often non-productive, with security concerns typically dominating any such discussions. Communication between providers and inmate patients is structured and non-confidential to the point that information necessary to provide adequate health care may not always be communicated.

The issue of balancing concern for patient needs with a healthy awareness that many patients will attempt to use health care as a tool to manipulate the system has been raised previously in the context of pain medication. The Task Force feels that this is a broader issue and one that gets to the heart of the atmosphere within which health care is provided at DCS. The constant need to be constantly suspicious of the motives of patient inmates, and to be wary for one's own personal safety, cannot help but blunt the caring instincts of dedicated providers over time.

The experience of the Task Force has led to the conclusion that neither the Ombudsman's Office nor DCS is the appropriate party to investigate and evaluate complaints from inmates regarding health care and treatment. This is partially due to the antagonistic atmosphere that has come to exist between these two parties, a subject that will be addressed in more detail below. But, primarily, this is so because DCS cannot provide the objectivity necessary for such investigations and the Ombudsman's Office cannot provide the medical expertise necessary to evaluate complaints. The absence of an impartial external body to whom inmate concerns can be addressed has resulted in both DCS and the Ombudsman trying to fill the gap, with predictably unacceptable results.

Access to inmate medical records has been an area of disagreement between these two parties as well. Ultimately, this issue must be resolved by the legal system in accordance with state laws governing access to documents and the nature of public records.

Finally, the Task Force wishes to ensure that there is active follow-up on those of its recommendations that are chosen by the Governor to be implemented. Such a follow-up evaluation will facilitate the transition of good intentions into good works and will allow the usefulness of the recommendations to be tested.

With these thoughts in mind, the Task Force makes the following ancillary recommendations:

1) DCS health care administrators, and especially the medical director, must continually emphasize and model the need to balance empathy for patient inmates with concerns about patients attempting to manipulate the system. Some inmate patients will attempt to do this regardless of attempts at countermeasures.

2) DCS leadership must improve internal communications within the agency, especially:
   - Among health care providers at different institutions
   - Between health care and security managers and staff
   - Among health care staff members
   - Between health care providers and inmates

3) An impartial external body is needed to provide a formal feedback mechanism for inmates vis-à-vis the delivery of health care. Possible candidates to serve in this capacity include:
   - The medical oversight committee described above, if one is appointed
   - Another agency of state government, such as the Health and Human Services Department of Regulation and Licensure
   - The State Board of Health
   - The University of Nebraska Medical Center

4) Male inmates with chronic or complex health problems should be housed in Lincoln or Omaha because of greater access to specialized care with reduced cost to DCS.

5) The entire issue of the current provision of inmate health care raises concerns about the liability of the DCS under the law.

6) DCS needs to develop special diets for patients with special needs such as diabetics. There is also a need for special diet education programs for chronically ill patients so that they can manage their condition when they are released from the correctional system.

7) Refrigerated medications should be stored separately from food.

8) There needs to be a clarification of who has the authority to release inmate records (and to whom) with appropriate provisions and accountabilities for confidentiality. As a general rule, no one outside of medical staff should have access to patient records unless the patient has given written permission.

9) A follow-up evaluation of the implementation status and the outcomes of implementation of Task Force recommendations should be conducted by

July 2002. This evaluation should be conducted by an impartial body external to DCS and the Ombudsman's Office.

N) An Observation

Early in the course of the study, it became evident that a significant state of animosity had evolved between the Office of the Ombudsman and DCS. This appears to be the result of years of disagreement between these parties over numerous issues of inmate rights and treatment, access to records, and security needs. Whatever the origins of the animosity, and whatever the original good intentions on the part of the parties involved, the polarization that has ensued is a major impediment to both the communication of concerns and the resolution of issues. Simply put, neither party trust information provided to it by the other, and each is suspicious to the point of discounting the motives and actions of the other. Significant energy is deflected from the common challenge of ensuring quality health care in a security environment by constant finger-pointing, bickering, and obstructionism that each party and its supporters displays toward the other. "Counting coup" has come to mean more than working together for the public good, and all citizens of Nebraska are lessened thereby. The Task Force cannot state too strongly its belief that a remedy to this situation must emerge before either the Ombudsman's Office or DCS will be able to carry out its mission successfully.

CONCLUDING REMARKS

The Task Force members through their recommendations seek to communicate their conviction that DCS health care services need to be brought into conformity with community standards of care. The Task Force members hope that the infusion of more independent medical oversight along with quality assurance programs that include participation by professional and public members from outside of the correctional system will eventually accomplish this task.

During Task Force deliberations, DCS personnel have provided information about changes being made in response to our more obvious findings (e.g., implementation of some improved quality standards and basic protocols, realignment of some physician responsibilities and supervision of PAs). These improvements, in the opinion of the Task Force, could be temporary and fall short of addressing the overall needs of the DCS health care system. Conducting a follow-up assessment within two years will help ensure that this does not occur.

The Task Force members wish to emphasize that, unless there is a significant restructuring of the administrative dimension of health care services at DCS to bring about greater coordination and communication with outside medical groups and experts, much, if not all, of their work to develop recommended improvements will have been in vain.

DCS leaders and employees are dedicated individuals who face immense challenges in their careers of caring for those members of society who have chosen, through their criminal acts, to set themselves apart. The culture that has arisen in this environment cannot, of necessity, be like that which pertains in the greater society. But there is no reason to expect that the outcomes of health care provided in the corrections environment should be significantly different from those outside. The Task Force members hope that the recommendations presented in this report will be effective in strengthening the achievement of a community standard of health care within the Department of Correctional Services.

APPENDIX 1: The Governor's Charge to the Task Force

The Governor's Task Force on the Department of Correctional Services Medical Services System is charged with a review of medical health services within the facilities at Lincoln, York, Omaha, Hastings, and those planned for the new facilities in Tecumseh and McCook. The group will report to the Governor regarding the adequacy of policies and practices governing the medical services system, to include:

- Consideration of recent reports, letters, and other sources of concern about medical health services;
- The identification of the need for immediate changes in existing policies where the health needs of inmates would require such changes, together with short term solutions; and,
- The identification of the need for long term changes, to include structural considerations and recommendations on how and who should undertake long term changes.

The Task Force will consider the following specific issues:

a) Training and equipment for emergency response including Advanced Cardiac Life Support training and defibrillation equipment;
b) Policies and practices regarding medical treatment within the facility or referral to specialists or hospitals outside the correctional facility including treatment of acute upper gastrointestinal bleeding;
c) Pain medication policies and practices;
d) Women's health issues;
e) Policies and practices regarding communicable diseases;
f) Surgery policies and practices including policies on elective surgery;
g) Structure of the medical services system including the respective roles of the Assistant Director of Corrections for Administrative Services, the Director of Health Care, the Assistant Director of Health Care, and the Medical Review Committee;
h) Staffing and staffing patterns;
i) Lines of authority for medical staff;
j) Balance between security concerns of correctional officers and treatment of medical conditions;
k) Balance between treatment of medical conditions and costs of treatment.

The Task Force on the Department of Correctional Services' Medical Services System will begin work in January 2000 with support from the Administrative Services Division of the Department of HHS Regulation and Licensure.

APPENDIX 2: IMQ Management Standards[1]

The following items regarding quality management are abstracted from the Institute for Medical Quality:

1) Necessary elements of quality management include:

- Identification of important problems or concerns
- Evaluation of frequency, severity, and source of problems or concerns
- On-site monitoring of health services on a regular basis
- Review of all deaths, suicides, and illnesses in custody
- Implementation of measures to address problems and concerns
- Re-evaluation of problems and concerns after corrective measures have been implemented
- Reports comprising information on the progress of QA efforts to the director
- Incorporation of findings of QA efforts into educational activities
- Maintenance of appropriate records pertinent to QA
- Provision for confidentiality of records pertinent to QA

2) There needs to be a facility disaster plan that includes written policy and procedures for the provision of health care in the event of some kind of disaster.

3) All health care examinations and interviews should be conducted in private.

4) Notification of next of kin or legal guardian should be part of written policy and procedure.

5) Every inmate death should be reviewed by the agency in cooperation with facility management and under written procedures.

6) There should be a grievance mechanism to address inmate complaints about health care services that is defined in writing and guided by established procedures.

7) External peer review should be under written policy guidelines and procedures.

8) A written plan for the detection, control, and treatment of communicable diseases should be created under the direction of a physician with input from facility administration and a local health officer.

9) Training programs for all correctional personnel should be established via written policy by responsible authority in the following areas:

[1] Accreditation Standards for Adult Detention Facilities, 1998, 1st ed., Institute for Medical Quality; San Francisco, 1998

- Signs and symptoms of an emergency
- Procedures for action for types of emergency situations
- Procedures for transferring patients to appropriate medical facilities
- Signs and symptoms of mental illness, retardation, emotional disturbance, and chemical dependency
- Signs and symptoms of communicable diseases and methods of prevention
- Suicide prevention programs

10) There should be a written policy and defined procedure for the management of pharmaceuticals to include:

- Compliance with state and federal laws
- Formularies for both prescribed and OTC medications
- Informing inmate patients regarding every new medication prescribed
- A method for notifying responsible practitioners of the expiration of a drug order

11) All correctional facilities shall have, on file, written and signed agreements with licensed acute medical and mental health facilities to provide services.

12) Written policy and procedure should be defined for screening of all inmates including new and transfers to the facility and such screening should include review of previous medications taken and any special chronic health problems and conditions that the inmates in question might have.

13) Written policy and procedure should guide the processing of inmate requests for health care, and such requests should be Documented daily. The response should be acted upon by trained health care personnel and followed by appropriate triage and treatment by qualified personnel.

14) Written policy and procedure should guide care at on-site ambulatory clinics. Sick call should be provided five days per week at least staffed by physicians, nurses, physician assistants, or some combination thereof.

15) Physician assistants should function under written protocols, and the supervising MD should be actively involved in the development of standardized protocols for them, and these standing orders should not be used unless specifically approved by the physician.

16) A program of health education should be provided to inmates under written policy, procedure, and practice.

17) Written individual treatment plans should be developed based upon written policy and procedure for patients with special medical needs.

18) First aid kits should be available in designated areas of each facility.

19) There should be written policies and procedures for patients with HIV and should include the following:

- When and where inmates are to be tested
- Appropriate safeguards for health care personnel
- Who should conduct the tests
- When and under what conditions inmates are to be separated from the general population and when they may return to the general population
- Medical referrals required
- Staff and inmate training procedures
- Issues of confidentiality

20) Public advisory committees that advise on health care policy and services should have at least one physician as a member.

21) Written policy and procedure on OTCs used following visits to sick call or to initiate self care should include the following provisions:

- The responsible physician or health authority along with custody administration shall determine which medications are to be OTC for each patient.
- There is a limit on the amount of a given medication that an inmate may purchase.
- Procedures must address monitoring and control of medication availability.
- A written plan must be provided for those inmates who have been determined should not have OTC medications.
- Indigent inmates need to have access to OTC medications regardless of ability to pay.

APPENDIX 3: ORGANIZATIONAL CHART not included in Web version.